BlueCare Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
bluecare.bcbst.com

BlueCare℠
TennCare*Select*

Private Duty/Skilled Nurse Visit/Home Health Aide/ Home Health Therapy Request Form

Initial Request or Extension of Services

Prior Authorization is required for all Home Health Services being rendered or within 24 hours of the next business day for emergency services. Prior Authorization is not required for Home Health Therapy services for members under the age of 21. Submit via the web or call the pre-service line:

BlueCare/TennCare*Select*
Phone 1-800-924-7141

Prior Authorization/Notification is required and services are needed beyond the number of services authorized by BlueCare Tennessee you must request that the services be extended prior to the end date of the initial Prior Authorization date. A written and signed MD order must be attached to this request.

To be completed by Physician

☐Urgent - life sustaining/adverse to member ☐Non-urgent

(Check requested service and indicate the specific duration of the requested service i.e. 24/7, 12/7 etc.)

☐ Home Health Aide Duration	☐ Skilled Intermittent Nurse Visits Duration	☐ Private Duty Duration
☐ Home Health Physical Therapy Duration	☐ Home Health Occupational Therapy Duration	☐ Home Health Speech Therapy Duration

Member Information		
Member Name (First, Middle, Last):	Member ID Number:	Member Date of Birth:
Member Address (Street, City, State, Zip)	Gender: Female ☐ Male ☐	Diagnosis Code

Provider and Supplier Information		
Physician Name:	Phone Number:	Fax Number:
Provider Number:	National Provider Identifier:	Tennessee Medicaid Number:

Original Start Date of Care:	**Dates of Service for this Reference**	**From:**	**To:**

The following information needed when requesting approval of new requests and to extend existing services (Please provide this information to us within 24 hours of receipt of this form):

Type of Care Needed: (What is the specific hands on care (SKILL) the member needs to treat his/her problem that the aide or nurse will do for the time he/she is in the home? What is the frequency or type for this care, i.e., twice a day, every six hours? Keep in mind housekeeping, laundry services, caregiver, monitoring or preparation of meals are not covered per new TennCare Guidelines. Behavioral Health services for BlueCare and TennCare*Select* members are coordinated through BlueCare Tennessee.

Home Health Aide/Medical Social Worker

(When Skilled nursing criteria is met, the nurse will provide Home Aide services)Please attach any supporting documentation

(Skill)	**(Frequency or Type)**
☐ Bath	
☐ ADL's	
☐ Hand Patient Medications	
☐ Patient Transfers	
☐ Vital Signs	

☐ Other - Please Specify	
☐ Social Worker Visit	

Provider Administration Manual

Skilled Nurse Visit	
(Skill)	**(Frequency, Type, Time Needed to Perform Skill)**
☐ Suction	
☐ Bolus Tube Feedings	
☐ IV and/or IM Medications	
☐ Venipunctures	
☐ Infections	
☐ Intravenous Feedings	
☐ Insertion and sterile irrigation of catheters/catheters care	
☐ Application of dressings (wound care) involving prescription medications and aseptic techniques	
☐ Treatment of extensive decubitus ulcers or other widespread skin disorders	
☐ Other - Please Specify	
Private Duty Nursing Services (PDN) - 8 hours or more	
(Skill)	**(Frequency or Type and Number of Hours)**
☐ Continuous Intravenous Therapy or TPN	
☐ Continuous Gastrostomy Feedings (include the time needed to begin,disconnect and flush - not the entire time the feeding is dispensing)	
☐ Nasopharyngeal and Tracheostomy Care - Stoma care, suctioning, humidification, changing a tracheostomy tube and emergency procedures for tracheostomy care	
☐ Monitor of ventilators - Positive pressure or negative pressure ventilation	
☐ Other respiratory therapies - Nebulizer, Chest PT	
☐ Other - Please Specify	

Home Health Therapy Visits: Prior Authorization not required for members under the age of 21

Problems:

1.

2.

3.

4.

Assistive Devices:

Rehab Potential:

Short Term Goals: (initial requests)

1.

2.

3.

4.

Target completion date

Long Term Goals: (initial requests)

1.

2.

3.

4.

Target completion date:

If therapy continuation, document the following: goals, progressing or not progressing, met:

ROM/strength/functional limitations:

Date of assessment:

Is there a trained family member or friend available as caregiver in the home? ☐Yes ☐No

Number of hours per day:_____Reference number if request is for extension of services:_____

Note - A request cannot exceed a maximum of eight (8) weeks in duration

This form is to be used for additional information and will work in conjunction with the CMS-485 and is not to be used as an order unless signed and specified below. This approval is subject to verification of all medical information and is valid only if such information is accurate and complete. Payment of benefits remains subject to all contract terms, conditions and exclusions and to the patient's eligibility for benefits at the time expenses are incurred.

Additional Information: ☐ Physician's Order: ☐

Date of Request:_____Physician's Signature:_____Date:_____